Lynn COMMUNITY health CENTER 269 UNION STREET • LYNN, MASSACHUSETTS 01901-1314 • (781) 581-3900 • FAX (781) 598-1050

March 3, 2010

David Morales, Commissioner
Division of Health Care Finance and Policy
Executive Office of Health and Human Services
Two Boylston Street
Boston, MA 02116

Dear Commissioner Morales:

Thank you for the opportunity to provide testimony in response to the findings on Health Care costs in Massachusetts.

1. After reviewing the preliminary reports located at www.mass.gov/dhcfp/costtrends please provide commentary on any data or finding that differs from your organization's experience and the potential reasons therefore.

Community Health Centers are not the drivers of health care cost inflation. We are part of the solution – an excellent example of the right care, at the right place, and at an affordable cost.

The Lynn Community Health Center has served as the primary source of health care services in one of the most severely medically underserved communities in the Commonwealth ever since our beginnings as a mental health center in a tiny storefront in 1971. LCHC is now the largest provider of primary care services in the city of Lynn, and this past year provided over 170,000 medical, behavioral health and dental visits to 33,286 patients. LCHC is the Medical Home to over one in three Lynn residents and 45% of all Lynn children under 18.

The tremendous growth in the demand for our services shows no sign of decreasing in the near future. Several factors contribute to the increased demand:

- Many adults in Lynn are employed in low-wage jobs that offer no health insurance, or insurance with premiums that are unaffordable for them and their families.
- More people in Lynn have become insured for the first time, as a result of Massachusetts' health care reform laws, requiring all residents to have health insurance. We have worked closely with the providers of the state's subsidized insurance plans to ensure everyone has access to quality care.
- Lynn's immigrant population is projected to grow 30% over the next five years and will likely utilize the Health Center.

Our emphasis on preventive primary care is critically important in keeping the cost of health care down. National studies have demonstrated that every dollar invested in Community Health Centers provides an average savings of three dollars to the overall health care system. This is a result of Community Health Centers' emphasis on aggressive chronic disease management and ongoing efforts to reduce unnecessary emergency room utilization through nurse case management and behavioral health crisis intervention.

We are also an employer and have experienced double-digit inflation for each of the past three years in the cost of providing health insurance for our employees. This is as significant a problem for us as it is for any other business.

2. Are there any competitive advantages for community health centers to affiliate with academic medical center? If so, what are they?

The Lynn Community Health Center is a free-standing independently licensed Community Health Center. We are affiliated with our local hospital, the North Shore Medical Center, which is part of Partners HealthCare System. Our affiliation has been a successful ongoing collaboration for the purpose of coordinating care for our patients, who require access to specialists and hospital care when those services are medically necessary.

Our affiliation has been a very positive one over the years, resulting in many joint projects:

- NSMC/Partners provided capital and operating support for the development of the Health Center's Walk-In Service in September 1999, which now provides over 17,000 visits per year, visits that would otherwise go to a hospital ER.

- Since 2000, NSMC has provided Lab and Radiology services, including Mammography, Ultrasound and General X-ray, on site at the Health Center's main site in downtown Lynn.

- During the past 5-10 years NSMC/Partners has assisted the Health Center in developing on-site specialty services, including Cardiology, Endocrinology, Pulmonology, General Surgery, Podiatry and Ophthalmology.

- Partners assisted in the development of the Health Center's 340B Pharmacy program, which opened in January 2000 and provided over 120,000 prescriptions to Health Center patients in 2009. 80% of the prescriptions were for low cost generic medications.

- In September 2002, NSMC/Partners provided capital financing and operating support to the Health Center to develop 2 new primary care practices in the

Market Square area of Lynn. During this past year, the two facilities in Market Square provided 18,605 primary care visits and 8657 behavioral health visits.

- In 2004, the Health Center and NSMC began a pilot project to reduce unnecessary ER utilization by developing a robust system for referring patients without primary care providers to LCHC for follow up care. The project included a strong nurse case management service at LCHC and the two hospitals ERs. The Health Center has been seeing over 400 new patients a year as a result of follow up referrals from the Salem or Union Hospital ER.

- In 2009, Partners and NSMC contributed $326,000 toward the expansion of Behavioral Health services at 23 Central Ave. and the opening of a new Eye Care Service in collaboration with the New England College of Optometry, in order to improve care to patients at risk for retinopathy (diabetics, particularly) and glaucoma.

- In 2009, LCHC and Partners initiated a pilot project to explore the feasibility of using technology to help improve health outcomes for low-income patients. We are testing the use of text messaging as a way of enhancing provider and patient communications for a group of patients without regular access to computers or the internet.

- Most recently, NSMC/Partners made a commitment to provide $3 million toward the financing of an expansion of the Health Center that will help us provide primary care and behavioral health services for an additional 4000 patients without other access to care.

3. With respect to the aggregate trends, what specific actions has your organization taken already to address these trends in the short term or long term?

The Lynn Community Health Center has undertaken a number of initiatives to measurably improve the health and coordination of care for our large population of low-income adult patients with serious chronic health and mental health conditions, such as diabetes, cardio-vascular disease, metabolic syndrome and depression. During the past year, we served over 6900 patients with these conditions.

Over the past several years, LCHC has been able to develop an innovative system for managing patients with these conditions using the data entered into our Electronic Health Record by providers in the course of documenting their care. We now regularly generate reports by provider on patient compliance with recommended clinical measures.

Our ability to identify, track and monitor clinical conditions and treatment outcomes with selected groups of high risk patients has allowed us to target follow-up efforts to those in most need.

During the past year, we have documented measurable and significant improvements in clinical outcomes in the very high-risk group of diabetic patients served by our team of Nurse Case Managers and Community Health Workers. For almost 89 low literacy Spanish speaking patients with high HgA1C levels who participated for a full year in an intensive diabetic education program, for example, pre- and post- SKILLD tests showed a significant increase in knowledge of Diabetes (an average of 58 in the pre-tests and 91 in the post-tests). Average HgA1C levels decreased in this very high-risk population from 10.6 to 8.5!!

Using EHR data, LCHC is also able to report that:

- As of December 2009, over 90% of the Health Center's very high-risk diabetic patients receiving case management services have had a documented HgA1c within the last six months.
- The total number of LCHC Diabetic patients with HgA1c below 7.0 has increased to 39% from 31.1% in December 2008.
- The total number of LCHC Diabetic patients with LDL below 100 has increased to 44.2% from 33.4% during 2009.

December 2009 data also show that our 1,765 patients with Diabetes have an average HgA1C of 7.79 – a significant improvement from over a year ago and the direct result of the work of our team of Nurse Case Managers and Community Health Workers.

These are significant improvements, due primarily to our ability to use EHR data to track these measurements over time, give timely information to providers, and provide nurse case management, care coordination and culturally appropriate care to the patients at most risk. These efforts have prevented the need for more expensive treatment. As a graphic example, a regular foot exam by a primary care provider that knows the patient is a lot less expensive than a foot amputation!

Given the success of this initiative, it would seem that it would be in the Commonwealth's interest to continue this effort. Instead the funding for the community health workers ended.

Imagine what we could do if we had the resources to provide this kind of case management and care coordination to more of our patients with chronic conditions!

3a. What current factors limit the ability of your organization to execute these strategies effectively?

- The shortage of primary care physicians
- Low reimbursement rates for primary care services – especially in Community Health Centers
- Even lower reimbursement rates for needed Behavioral Health services
- The lack of any financing mechanism to pay for the nurse case managers and community health workers needed to provide preventive care and coordination of

care for high risk patients with chronic illnesses – patients that will otherwise end up using more expensive ER and other institutional care.

4. What types of systemic changes would be most helpful in reducing cost trends without sacrificing quality and consumer access? What other systemic or policy changes do you think would encourage or help health care providers to operate more efficiently?

Community Health Centers are not the drivers of the current cost inflation. Moreover, investing in more primary care services on the front end of the health care system will help prevent or reduce unnecessary care and over-utilization. Following are some feasible changes that would help leverage the development and expansion of preventive and primary care.

- Invest more in training for both physicians and mid-level providers who agree to become primary care providers. If physicians did not have to acquire so much debt to complete their training, many would be more interested in pursuing primary care careers, which are less lucrative than most specialties.

- Increase reimbursement rates for primary care services relative to specialty services, and develop a mechanism to pay for intensive case management for patients with complicated chronic medical conditions. At the current time, the financial benefit from the case management services we provide at LCHC for high-risk patients accrues only to their insurers.

- Impose a co-payment for Medicaid and other publicly insured patients who use the ER for non-emergent care. Most private insurance plans do this to prevent or reduce unnecessary ER utilization.

- Invest in community health center dental services to promote oral health and prevent dental disease. Insufficient access to preventive and restorative dentistry results in patients with acute dental pain inappropriately using ER's. Affordable community-based dental services will save teeth and resources.

- Invest in systemic support for facility expansion and information technology infrastructure at community health centers in order to expand access to primary care. Our very successful Electronic Health Record system, for example, has been a costly undertaking, including ongoing maintenance and support, for which there has been no regular source of funding.

- Maintain Pharmacy Services within the MCO contracts for Medicaid and the Commonwealth Care Plans in order to improve care coordination. Managing pharmaceutical and other medical benefits under one entity enhances care coordination and promotes improved health outcomes and cost-effective care. Relying on communication and data exchange between multiple entities will lead to fragmentation of care, adding far more to the cost problem than the available rebates from drug companies.

- Streamline government reporting requirements for Community Health Centers. Reporting requirements have become increasingly onerous in recent years: resulting in added administrative expense. Some examples:

  - The Department of Public Health requires separate data reporting for each program – most of which are manual and time consuming. If they allowed Health Centers to submit their EHR data, this would save significant duplicative administrative cost.

  - EOHHS now requires vendors (us) to research and download changes in billing procedures (frequent these days!). This likely saves the Commonwealth money, but transfers significant administrative cost to us. If there were consistent electronic billing and claims formats for all state agencies (i.e. MassHealth and HSN), that would help reduce cost!

  - Efforts by the Department of Medical Assistance to save money by overzealous denial of claims force Health Centers to employ additional billing staff to research denials.

  - Frequent re-determinations of Medicaid eligibility require us to maintain a large staff (10 FTE's) to assist patients in repeatedly re-applying for MassHealth, Commonwealth Care or the Health Safety Net.

  - Regulations requiring individual billing numbers for each Health Center location means that our staff must prepare and authorize referrals for patients who see their own provider when that provider is located at a different site. This also means an additional step for our billing staff for each encounter and unnecessarily complicates reporting.

- Re-institute regional health planning and strengthen the Determination of Need process to help prevent the duplication and over-expansion of expensive (and lucrative) health care technology and institutional care.

5. Could enhanced competition or government intervention or a combination of both mitigate the cost trends found in the Division's report? Please describe the nature of the changes you would recommend. In addition, please address the following:

a. What would be the impact on your organization of making data public regarding quality and the reimbursement rates paid by each carrier to each hospital or system in a manner that identifies all relevant organizations? What is the advantage or disadvantage to your organization of the current confidential system?

Competition between providers has contributed to the duplication of facilities and technologies in geographic areas where there are more privately insured patients.

Government intervention and regulation is needed to assure more equitable distribution of service access to all residents of the Commonwealth. Under the current system, the wealthier organizations fare better than those with fewer resources – which only serves to increase the very real racial and ethnic disparities in virtually every indicator of health. If you consider the significance of the resources being spent on health care in Massachusetts, it should be simply unacceptable to allow for these disparities to continue to grow.

If the Accountable Care Organizations that are being considered are to be truly accountable, their focus should be as much about reducing racial, ethnic and income disparities in care as about reducing costs. Accountable to who? and for what? In a global payment mechanism, a powerful incentive to expand preventive primary care and more rationally distribute tertiary and quarternary care will be necessary to be successful in reducing cost.

More transparency of information regarding quality and reimbursement rates would be a positive thing, from any consumer perspective. However, it is important that health outcome and quality measurement reports take into account the persistent health disparities among different patient populations. The patient populations served by Community Health Centers and Disproportionate Share Hospitals, for example, are significantly more challenging to manage than the white, employed and well insured populations served by some hospitals and private physician practices. Providing data without describing the significant economic, social and demographic variables contributing to the findings would be misleading and damaging to providers that serve challenging patient populations.

6. Please identify any additional cost drivers that you belive should be examined in subsequent years and explain your reasoning.

One of the most significant cost drivers is the aging of the population. The outsized baby-boomer generation has reached the age when medical utilization normally increases. Programs like PACE (Program for All-Inclusive Care for the Elderly) and SCO (Senior Care Options) have demonstrated their ability to reduce the cost of care for frail and community-well seniors that are dually eligible for Medicaid and Medicare. These are successful programs that should be expanded to larger portions of the aging population.

Despite the negative rhetoric about Death Panels, end of life care is another significant cost driver that could benefit from much more public discussion about Advanced Directives. Many people do not really want to spend their last days in expensive institutional settings, hooked up to machines, etc. and yet they often do, at significant expense.

7. Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations:

As part of a CMS funded pilot project with the Neighborhood Health Plan, the Health Center developed two program initiatives:

- We added two nurses to: (a)strengthen our collaborative effort with the North Shore Medical Center in identifying Health Center patients using the ER and following up with these patients to re-connect them with primary care, and (b) improve telephone access to a triage nurse at the Health Center during peak times.

- We developed a Behavioral Health Response Team to improve our capacity to respond to urgent or acute behavioral health needs at the Health Center during daytime, early evening and Saturday hours, and to help foster a more integrated approach to the delivery of behavioral health and primary care for patients with chronic medical and mental health problems.

Data from NHP indicates that Lynn Community Health Center patients reduced the number of non-emergent ER visits per 1000 NHP member years by 6% from the period 10/1/2007-9/30/2008 to the period 7/2008-6/30/2009. There was a reduction of 43% for week day/work hour non-emergent ER visits per 1000 LCHC NHP members during that same period.

It appears that both the nurse case management collaboration between the Health Center and the NSMC and the development of the Behavioral Health Response Team have contributed to a measurable reduction in unnecessary ER care.

Given the success of this initiative, it would seem as if it would be in the Commonwealth's interest to continue this effort. Instead, the funding ended.

Thank you for the opportunity to provide written testimony on this very important topic.

Sincerely,

Lori Abrams Berry
Executive Director